Sowell

Patient Information

Contact Information

Name: _____
First Middle Last Preferred Name

Address: _____ Apt. or Suite # _____

City: _____ State: _____ Zip: _____

Gender: Female Family Status: Single Spouse or Parent's Name: _____

Social Security #: _____ Date of Birth: _____ DL # _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone: _____

Email Address: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time

Preferred Day: ☑M ☑T ☑W ☑T ☐F

In Case of Emergency Who Should We Contact? _____ Relationship _____

Emergency Contact Numbers _____

Spouse or Responsible Party Information

To Be Filled Out if Different from You
The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ Both

Name: _____
First Middle Last Preferred Name

Address: _____ Apt. or Suite # _____

City: _____ State: _____ Zip: _____

Gender: Female Family Status: Married

Social Security #: _____ Date of Birth: _____ DL # _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone: _____

Employer Name: _____ Position: _____ Phone Number _____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Position: _____

Address: _____ Apt. or Suite # _____

City: _____ State: _____ Zip: _____

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Insurance Information

Primary

Name of Insured: _____
Last First MI

Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Address: _____ Apt. or Suite # _____

City: _____ State: _____ Zip: _____

Insured's Employer Name: _____

Address: _____ Apt. or Suite # _____

City: _____ State: _____ Zip: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____
Last First MI

Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Address: _____ Apt. or Suite # _____

City: _____ State: _____ Zip: _____

Insured's Employer Name: _____

Address: _____ Apt. or Suite # _____

City: _____ State: _____ Zip: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Referral Information

Whom may we thank for referring you to our practice? ☐ Friend ☐ Relative ☐ CosmeticDentistFinder.com

☐ Dental Office ☐ Internet ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

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Dental & Medical Information

Dental History

Name of Last General Dentist: _____

Address: _____ City _____ State _____ Zip _____

Have You Requested for Your Records to be Transferred to Us? ☐

If No, Would You Like Us to Request Your Records for You? ☐

Date of Last Dental Visit:: _____ Reason for this visit: _____

When Was Your Last Dental Cleaning? _____ When Were Your Last Dental X-Rays Done? _____

Do You Floss Your Teeth? ☐ If Yes, How Often: _____

What Kind of Toothbrush Do You Use: Manual If Electric, What Make or Model Is It: _____

Have You Ever Had Complications Following Dental Treatment? ☐ If Yes, Please Describe: _____

_____

_____

Have You Been Advised To Take Antibiotics Prior To Dental Treatment? ☐ If Yes, Reason: _____

If Yes What Do You Take: _____

Have You Ever Had A Complication or A Reaction To Dental Anesthetics? ☐ If Yes, Please Describe: _____

_____

Orthodontics

Have You Ever Been to An Orthodontist? ☐

Have You Ever Had Orthodontic Treatment? ☐ If, Yes When Did You Have Treatment _____

What Type of Treatment Did You Have? None *Other*: _____

Are You Under The Care of An Orthodontist Now? ☐

Orthodontist's Name: _____ City _____ State _____ Zip _____

Periodontics

Have You Ever Been To A Periodontist? ☐

Did You Have Periodontal Treatment? ☐

What Type of Treatment Did You Have? _____

Are You Under Their Care Now? ☐ If Yes, What Type: _____

Periodontist's Name: _____ City _____ State _____ Zip _____

TMJ – Jaw Joints

Do Your Jaws (TMJ) Pop, Click or Lock? _____ If Yes, Which Side(s) and How Often: _____

_____

Do You Have Pain When you Jaws Pop, Click or Lock? ☐ Which Side(s)? Right

Do you currently wear a removable acrylic appliance? ☐

Pain

Do You Have Dental Pain or Discomfort Other Than TMJ Now? ☐ If Yes, Please Describe: _____

_____

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Medical History

Have you ever had any of the following? Please check those that apply:

☐ Vascular Heart Disease
Please Describe: _____
_____
_____
☐Heart Attack(s)
Describe: _____
_____
☐Heart Rythum Problems
Describe: _____
_____
☐High Blood Pressure
☐Stroke
☐Low Blood Pressure
☐Heart Murmur
☐Aneurisms
Describe: _____
_____
☐Rheumatic Heart Fever
☐ Mitral Valve Prolapse
☐ Anemia
☐ Blood Diseases
☐Artificial Joints

Type(s): _____
_____
☐ AIDS
☐ Hepatitis
☐ Hepatitis B
☐ Hepatitis C
☐ Hepatitis D
☐ Other: _____
☐ Asthma
☐ Diabetes
Type: _____
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding Following Any Surgery or Injury
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Jaundice
☐ Kidney Disease

☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date: _____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐Mouth or Lip Ulcers
How Often Do You Get Them:
_____
Are You Using Anything To Treat Them: _____
What Are You Using:_____
_____
☐ Tumors

☐ Venereal Disease

Allergies/ Bad Reactions to:
☐Penicillin
☐Erythromycin
☐Cephalexin (Keflex)
☐Clindomyacin
☐Aspirin
☐NSAIDS – Non-Steroidal Anti Inflammatory Drugs
☐Codeine products
☐Other: _____
_____
_____
_____

Please List ALL Drugs and Medications You Are Taking (Both Prescription and Non- Prescription Drugs):

_____

Have You Ever Been Treated For Cancer? ☐ If Yes, Please Elaborate: _____

_____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

Name of Physician(s): _____ Phone: _____

_____ Phone: _____

When did you last visit your physician? _____ Why did you see your physician? _____

_____

Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

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Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will becharged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

Photographs: I agree to allow Mark A. Sowell, DDS and their agents to use the photographs of any portion of my dental treatment for the purpose of teaching, in dental & health publications, and any marketing or advertising medium including but not to the Internet.

I grant my permission to you or your assignee, to telephone me at home, on my cell or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient::_____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient::_____
Signature of guarantor of payment/responsible party

Release of Information

To whom may we release information about your appointment? ☐ **Spouse/Partner** ☐ **Children** ☐ **Parents**

☐ **Employer** ☐ Other, please specify _____

To whom may we release information about your dental treatment? **?** ☐ **Spouse/Partner** ☐ **Children** ☐ **Parents**

☐ **Employer** ☐ Other, please specify _____

_____ Date: _____
Patient Signature

Submit Secure Form